STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445205	A. BUILDING _____ B. WING _____	C 09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE CARE AND REHAB	**8249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An investigation of complaints #48592, #48910, #49033, and #49119 was conducted on 9/23/19 - 9/25/19 at Woodland Terrace Care and Rehab. Deficiencies were cited related to complaint #48592 under 42 CFR 483, Requirements for Long Term Care Facilities.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of a facility investigation, medical record review, observation, and interview, the facility failed to prevent abuse for 1 resident (#2) of 7 residents reviewed for abuse. The findings included: Review of facility policy Abuse Neglect, Mistreatment and Misappropriation of Resident Property, last revised 10/2017, revealed "...it is	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 600	Continued From page 1	F 600		

the policy of this facility to prevent abuse...Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pair or mental anguish...Willful as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm..."

Review of a facility investigation dated 7/27/19 revealed on 7/27/19 at approximately 11:00 AM Resident #6 entered Resident #2's room. Further review a nurse entered Resident #2's room after hearing the residents cursing loudly. Continued review revealed as the nurse was removing Resident #6 from Resident #2's room; Resident #6 reached over and hit Resident #2 on the foot. Further review revealed the nurse grabbed Resident #6's arm and placed it close to his body, but Resident #6 quickly reached back and hit Resident #2's foot again.

Medical record review revealed Resident #2 was admitted to the facility on 2/11/16 and readmitted on 11/17/18, with the diagnoses including Huntington's Disease (brain disorder), Dysphagia (difficulty swallowing), Dementia without Behavioral Disturbance, Dysthymic Disorder (depression), and Generalized Anxiety.

Review of Resident #2's Quarterly Minimum Data Set (MDS) dated 7/5/19 revealed a Brief Interview for Mental Status (BIMS) was not completed due to "...resident is rarely/never understood..." Review of a Staff Assessment for mental status revealed the resident's short and long memory was good.

Medical record review revealed Resident #6 was

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F 600	Continued From page 2	F 600		

admitted to the facility on 8/1/17 and discharged 8/16/19 with the diagnoses including Adult Failure to Thrive, Schizoaffective Disorder, Generalized Anxiety, Alcohol Dependence, and Bipolar Disorder.

Review of Resident #6's Annual MDS dated 6/19/19 revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating the resident had severe cognitive impairment.

Observation and interview with Resident #2 and Licensed Practical Nurse (LPN) #1 on 9/23/19 at 10:20 AM, in the hallway outside the resident's room, revealed the resident was seated in a wheelchair, was well groomed, and had no anxious or fearful behaviors. Interview with Resident #2 revealed "...[Resident #6] hit my foot (translated by LPN #1)..."

Telephone interview with LPN #2 on 9/23/19 at 1:40 PM revealed "...He [Resident #6] was in [Resident #2's] room visiting her roommate... [Resident #2] was yelling so I went in the room and was rolling him [Resident #6] out. When we passed the foot of her [Resident #2's] bed he [Resident #6] reached out...hit her [Resident #2's] foot...before I could get [Resident #6's] arms he hit [Resident #2's] foot again...he meant to hit her..."

Interview with the Director of Nursing on 9/25/19 at 11:18 AM, in the conference room, confirmed Resident #6 deliberately hit Resident #2 on her foot twice.

In summary, the facility failed to prevent abuse to Resident #2.